* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 1625-94

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED–NAME (First Middle Last): JAMES L. WARWICK
2. SEX: Male
3a. TIME OF DEATH: 10:42PM
3b. DATE OF DEATH (Month Day Yr): July 22, 1994
4. SOCIAL SECURITY NUMBER: 415-38-6861
5a. AGE - Last Birthday (Years): 66
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): Sep 29, 1927
7. BIRTHPLACE (City and State or Foreign Country): GLOMAR, HAZARD CO., KY
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1947
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY TOWN OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): JULIA RIDENOUR
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ROLLER HELPER
12b. KIND OF BUSINESS INDUSTRY: LTV STEEL
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 601 VAN BUREN STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE - American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JAMES WARWICK
19. MOTHER'S NAME (First, Middle, Maiden Surname): GERTRUDE HICKMAN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JULIA WARWICK
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 VAN BUREN STREET, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jul 26, 1994 CALVARY CEMETERY
21c. LOCATION - City or Town State: PORTAGE IN
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

CAUSE OF DEATH

28. PART I. Enter the diseases, injuries or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): HEALTH DEPT

a. JUL 28 1994 DUE TO (OR AS A CONSEQUENCE OF)

b. DUE TO (OR AS A CONSEQUENCE OF)

Conditions if any which gave rise to the immediate cause stating the underlying cause last

c. DUE TO (OR AS A CONSEQUENCE OF)

d.

T Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT WITHIN 90 DAYS PRECEDING DEATH? (Yes or No)

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): No

CERTIFIER

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.
☐ HEALTH OFFICER On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) as stated.
☐ CORONER On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: P.J. Tara MD
29c. MEDICAL LICENSE NO: 01031667
29d. DATE SIGNED (Month Day Year): July 28, 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): P.J. TARA MD, 8127 MERRILLVILLE ROAD, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alternate L. Williams M.D.
LAKE COUNTY HEALTH COMMISSIONER
32. DATE FILED (Month Day Year): 7-28-94

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month Day Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify):
34f. LOCATION (Street and Number or Rural Route Number City or Town State):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.:

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SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

HOLD FOR MERIDIAN TITLE CORP